The Cost of Health Care in Maine

An analysis of health care costs,
factors that contribute to rising costs,
and some potential approaches to stabilize costs.

Report of the

YEAR 2000 BLUE RIBBON COMMISSION ON HEALTH CARE

to

Governor Angus S. King, Jr.

November, 2000

The Year 2000 Blue Ribbon Commission on Health Care was appointed by Governor Angus S. King, Jr. on February 1, 2000 to identify the cost elements of Maine's health care system, identify factors that are driving up health care costs, examine cost shifting, and offer some potential strategies for stabilizing health care costs.

Members of the Commission

Robert Woodbury, *Chair*: Acting Dean, Muskie School of Public Service, University of Southern Maine; Former Chancellor, University of Maine System; Former President, University of Southern Maine.

William Beardsley: President, Husson College; Chairman, New England School of Communications; Treasurer, Member of the Board, Finance Authority of Maine; Member, Past Chairman, Maine Higher Education Council.

Joseph Carleton: Attorney at Law; Former Member of the Maine State Legislature's Banking and Insurance Committee which deals with health care.

Thomas Moser: Founder, Thos. Moser, Cabinetmaker; Founding Board Member, Maine Employers' Mutual Insurance Company; Member, Board of Visitors and Osher Library, University of Southern Maine.

Pamela Plumb: Principal, Pamela Plumb and Associates; Former City Councilor and Mayor, Portland, Maine; Former President, National League of Cities.

The Maine Development Foundation served as the Commission Secretariat, with Craig Freshley as lead staff. Henry Bourgeois, the foundation's president, was integrally involved.

The research was performed in partnership with the Edmund S. Muskie School of Public Service, University of Southern Maine, with Gino Nalli as principal researcher.

Visit the website of the Commission on Health Care at www.mdf.org/chc for background papers, bibliography, minutes of meetings, text of presentations, and more.

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Background papers and bibliography available at website

EXECUTIVE SUMMARY

On February 1, 2000, Governor Angus King appointed the Year 2000 Blue Ribbon Commission on Health Care by Executive Order. Comprising Robert Woodbury, chair, William Beardsley, Joseph Carleton, Tom Moser, and Pam Plumb, the commission had four primary charges:

· identify the cost elements of Maine's health care system, taking into account the state's demographic profile;
· determine the current allocation of costs and cost shifting among participants in the health care delivery system;
· recommend potential strategies for stabilizing overall health care costs;
· identify payment options for health care services, including the impacts of such options on costs and utilization.

To meet those challenges, the commission, with administrative support from the Maine Development Foundation, engaged research consultants, held both working and topic-specific meetings, solicited comments from members of the health care community and the general public, and held an all-day conference.

The commission's first task was to examine the myths and realities of the state's health care system. Among the things we discovered:

· We don't allow health care delivery to operate as a market in the true economic sense. Unlike in a traditional marketplace, we are not prepared to let those unable to pay go without. Furthermore, the health care system has no real accountability, contains few incentives to encourage better behavior, and encompasses no common understanding of terminology. Its consumers and providers are neither sensitive to—nor in many cases aware of—price, and its market in Maine is too small and too sparse to encourage meaningful competition.

· Mainers are not particularly healthy. In fact, and despite a general belief that there is nothing an average citizen can do to decrease health costs, Mainers smoke too much, eat too much, and generally do not live healthy lives. Thus many of the most expensive medical procedures stem from individual behavior.

We also examined the social context in which health care takes place, that is, the importance of health care in the community, of public health efforts, and of other government policies and programs. In addition, we considered the relevance of environmental and economic development policies to health care. Some of the conclusions we reached:

· "Health care" is much broader than services in a physician's office or hospital. It also encompasses a great deal of care provided by family members and communities, as well as public health efforts, and even recreation and fitness opportunities.

· Federal policy drives much of Maine's health care delivery system. Approximately one-third of the state's citizens are covered by Medicare (federal program that insures health care for the elderly) and Medicaid (state program funded mostly from federal sources).

· Maine has the highest percentage of uninsured people in New England. On the whole, that group - 40 percent of which earn between $10,000 and

$15,000 annually - has much higher rates of serious disease and morbidity than the rest of the population. In other words, those individuals need more acute - and expensive - care than others, and are more likely to die at a younger age. About 18,000 of Maine's children are uninsured (11,000 of these children appear to be eligible for government insurance programs but are not enrolled). The fact that so many children are uninsured holds serious implications for the cost of health care in the future: children who do not receive needed health care often become adults with serious health problems.

We performed a significant study of the actual cost of health care in the state. Among its many findings:

· The citizens of Maine spend almost five billion dollars a year for personal health (an average of nearly $4,000 per person), an amount representing nearly 14 percent of Maine's gross state product. By 2010, that number is expected to be approximately $9 billion, with the largest increases coming in home health care and drugs, and the smallest in hospital and physician services.

· Compared to the nation as whole, Maine spends more on home health care, nursing home care, and insurance administration. It spends less, however, on hospital care and physician services. It also spends much less than the national average on public health efforts.

· Maine receives less federal reimbursement for Medicare than most other states: about 80 cents for each dollar spent. The shortfall—approximately $100 million—is shifted to other populations for payment.

· The cost of health services differs widely across Maine, sometimes by thousands of dollars.

· Charity care and bad-debt write offs account for about $163 million annually in Maine.

· Drivers of high health care costs include both the concrete and the abstract: high demand; emotional considerations; aging population; insensitivity to the costs of treatments; the price of prescription drugs; lack of meaningful performance measures; the sheer complexity of the system; and government mandates all contribute.

· Cost shifting occurs in many forms and contributes to system complexity and uneven treatment of consumers.

With an understanding of the social factors that affect health care in Maine, as well as with data analysis upon which to peg our real work, we arrived at a three-part statement of the problem with health care in Maine:

The health care delivery and financing system is inefficient, unreasonably complicated, and unfair. Like the rest of the United States, Maine is not getting the most for its health care dollar. The system is marked by bureaucratic snarls, overwhelming paperwork, duplicative and unnecessary services, inefficient means of delivery, considerable finger-pointing, and nearly incomprehensible financing. Further, the system does not treat people fairly in terms of access to services and how much is paid out-of-pocket.

People in Maine are not as healthy as they could be, and efforts to improve health status are inadequate. There is much evidence that Maine's health problems stem in large part from poor personal choices and behaviors, albeit that the choices of many are limited. To the degree that behaviors change, the overall cost of health care will decrease. Further, Maine's public health endeavors could be more effective.

Many in Maine are unable to obtain health care of the type and quality that they need. "Access" is a significant problem in health care in Maine: access to insurance; access to physicians; access to hospitals; access to relevant data and information of all kinds; and access to sustained, systemic public health efforts. Access in all those areas depends greatly on geography and socioeconomic status, as well as on an ability to comprehend the system.

Prior to identifying various approaches to affect the long-term costs of health care, we determined a set of principles we believe should serve as a starting place for discussion:

· All Maine citizens should have ready access to basic health care regardless of income, location, or pre-existing or chronic conditions.

· Maine's health care system should be characterized by excellence, zero tolerance for medical errors, and appropriateness of care in accordance with outcome-based evidence.

· An increasing portion of the state's health care expenditures should go directly to disease prevention and public health efforts.

In the context of all we have learned, we offer a set of approaches worthy of serious consideration, even though we do not each fully support each approach. These approaches are aimed at stabilizing overall health care costs and improving the value of the health care delivery system.

Health Status

1. Encourage healthy communities via improved integration of social, economic and political factors.
2. Establish a network of public health physicians to identify and react to public health threats.
3. Improve youth health via school based health centers and coordinated school health programs.

Public Policy

4. Create a Maine Health Policy Council to establish consensus objectives and monitor progress.
5. Improve information for consumers and policymakers via improved reporting and data availability.

Efficiency and Quality

6. Improve medical records in terms of portability and personal involvement.
7. Improve clinical information for better physician decision making.
8. Improve administrative efficiencies via streamlined claims forms and credentialing.

Access

9. Change Medicare reimbursement policies through a number of avenues.
10. Expand insurance coverage among individuals and small groups via one or more of the three following approaches:
a. Encourage and facilitate private insurance companies to cover small businesses and individuals.
b. Create a mutual health insurance fund to provide coverage to the uninsured, small businesses, and individuals.
c. Create a universal, single payment program that protects all citizens from catastrophic financial loss as a result of sickness or accident.
11. Expand health care insurance coverage for all children via increased enrollment in, and expansion of, current government programs.
12. Expand Medicaid coverage to more disadvantaged people and review reimbursement rates.
13. Advocate for a national financing system that is centrally financed but delivered via decentralized, market-based mechanisms.

Lastly, we each offer our own final comments that serve to emphasize various aspects of the report, and in some cases, register disagreement with certain aspects. We came together with vastly different, and in many respects, relatively uninformed opinions about the cost of health care in Maine. While we learned a great deal together, and developed many shared perspectives, we none-the-less developed some individual opinions we thought worth sharing.

At our website, www.mdf.org/chc, one can find a bibliography for this report, background papers and much other information related to our work.

Chapter 1
INTRODUCTION

In late 1999, the health insurance market in Maine was beset by trouble and change. Specific problems included:

· Significant underwriting losses reported by the major health insurance companies in the state;

· A decision by Tufts Health Plan, a major provider of insurance to small employers, to cease operations in the state;

· Uncertainty as to the continued operations of Harvard Pilgrim Health Plan;

· The acquisition of Maine Blue Cross Blue Shield, the state's largest not-for-profit health insurance company, by Anthem Blue Cross, a mutual insurance company headquartered in Indiana;

· The decisions of a number of smaller, indemnity insurance plans serving the individual market to cease operations;

· Dramatic increases in premium costs among those companies still writing insurance in the state.

In response to those issues, and the rising cost of health care in general, Governor Angus S. King, Jr. appointed the Year 2000 Blue Ribbon Commission on Health Care on February 1, 2000. Comprising Robert Woodbury, chair, William Beardsley, Joseph Carleton, Tom Moser, and Pam Plumb,[1] the commission had four primary charges.

· Identify the cost elements of Maine's health care system, taking into account the state's demographic profile;

· Determine the current allocation of costs and cost shifting among participants in the health care delivery system;

· Recommend potential strategies for stabilizing overall health care costs;

· Identify payment options for health care services, including the impacts of such options on costs and utilization.

To meet those daunting challenges, the commission members have worked diligently for nine months. With administrative support from the Maine Development Foundation, we commissioned research and reports; held four regional meetings, six topic-specific exploratory meetings, and 18 working meetings; heard 17 presentations by experts; and solicited both general and specific comments from countless physicians, scholars, administrators, patient advocates, health-care providers and public interest groups, as well as from many of Maine's citizens. We also held an all day conference on our preliminary findings, one that encouraged participants to help us refine our thinking and our recommendations. (The minutes of our meetings, along with background reports, presentations, and public comments, are on-line at www.mdf.org/chc.)

Any report of this scope owes a considerable debt to many. The members of the commission wish to thank the myriad able, committed, conscientious health care professionals who took the time to comment on our efforts, attend our sessions, provide us with relevant information, increase our understanding, and point out our errors. Their assistance was invaluable as we struggled to craft a useful, credible document for the governor, the legislature, and the citizens of Maine. We are grateful for their aid to

our deliberations.

In addition, it is very important that the commission acknowledge that we saw and learned many exceptionally good things about Maine's health care system. Maine leads the country in some critically important measures of community health, such as childhood immunizations and low rates of teenage pregnancy. In addition, the state has made impressive progress in insuring children. Within the state, cardiac, oncology and other sophisticated acute care services rival those of the nation in quality and, in some cases, in cost effectiveness. Maine's system of providing home and community-based long-term care services is commendable.

And there are dedicated people working diligently to improve health care in our state. For example, national recognition is attaching to efforts in Franklin County to enhance community health. In addition, a program in central Maine is attempting to better coordinate free physician and pharmacy services provided to the uninsured.

As a commission, we acknowledge and compliment those efforts. We wish to build on them by identifying additional opportunities for improvement.

Before focusing on the specifics of our findings and our options for further consideration, we summarize here, from a broad policy perspective, our observations.

Maine spends a large amount of money on health care. Personal health care expenditures in 1999 are estimated to be $4.7 billion. At nearly 14 percent, Maine's health care spending, as a proportion of total gross domestic product, is larger than that of the United States as a whole (US health care spending is about 12.3% of gross domestic product). Furthermore, the cost of health care and health insurance has risen far faster than inflation in recent years.

In many ways, health care enterprises are an enormously positive part of the Maine economy. In general, they have many of the employment and economic characteristics that we welcome and prize in other business activities. The health care system offers productive, meaningful employment for thousands of the state's citizens: one in 10 Maine jobs is tied to health care; hospitals are the state's fourth largest employer.[2] To the extent we tinker with the health care system, we may significantly affect the prosperity of many of our neighbors.

Maine lags behind other states in important measures of health. Mainers live three fewer years than our neighbors in New Hampshire, for example.[3] Dr. Dora Mills, director of the Bureau of Health, indicates that cancer, diabetes, heart disease, and lung disease are responsible for 70 percent of the health care problems in Maine. While all four of those can strike people who take care of themselves, they affect more often those who have not done so. Thus some of our most chronic and costly health problems are preventable: results of our own choices.

Given those observations, does Maine's health care system provide a value commensurate with a $4.7 billion investment? We believe that better value can be achieved.

Health care may be the most complex domestic issue that faces Maine and the country. As this report reflects, there are no easy answers or "silver bullets" Maine can adopt to ameliorate health care costs. As professionals in areas other than health care, the commissioners were impressed with the complexity and interdependencies of the industry as a whole. It became very clear that factors contributing to higher costs are often linked to other underlying social and economic priorities.

Rural hospitals provide a ready example. In some cases, those institutions are underutilized, or utilized inappropriately, and are expensive and financially at risk. Thus one might make an objective argument that such institutions should be closed and replaced with other, less capital-intensive facilities. However, for many communities hospitals offer, in addition to nearby health services, the largest concentration of well paying jobs, are a source of pride and community identification, and, like good schools, represent an opportunity to attract new business and jobs to the area. In such cases, local economic considerations, not health care concerns alone, may drive opposition to closings.

Our values and culture often do not allow "competitive market forces" to operate when it comes to providing health care. The commission heard and read a great deal about the relative advantages of a market-based approach to allocating health care resources. And indeed, in some cases, the market works very well.

Our societal values and culture are not prepared to deny health services to individuals in need. Similarly, we believe that an individual should receive whatever services are necessary and appropriate in times of need. Yet a traditional market-based system does not accommodate such a birthright to health care. Thus our culture is unlikely ever to accept market dynamics alone to resolve fundamental issues as they relate to access, availability, and affordability-particularly in times of medical need.

Indeed, the health care market has a near-complete nontraditional dynamic. While an exhaustive analysis of medical economics is outside the scope of this report, the members of the commission believe some of the differences are important to our work.

Traditionally, demand is tempered by price. In health care, however, many consumers are largely protected from price through either public or private insurance arrangements. Thus they usually do not consider price when they consent to a particular diagnostic test or therapeutic treatment suggested by their physicians. Neither do physicians have sufficient price information to make recommendations based on cost of treatment. Finally, most physicians and consumers do not face direct financial consequence of their purchasing decisions.

In addition, traditional markets also presume that consumers have information adequate to exercise rational and efficient purchasing decisions. Health care consumers, however, will probably never achieve that level of knowledge. While there have been laudable attempts to provide more information to consumers in recent years, scientific advances in medicine and treatments will undoubtedly outpace individual understanding. Technology has certainly facilitated more understanding of the practice of medicine, but in fearful and anxious times, consumers find it easier and more comforting to trust their doctors.

Then, too, meaningful measures of quality health care are primitive—and exceptionally complicated. It will be difficult for an average consumer, for instance, to ever understand what "age-adjusted death rate" is.

The question of barriers to entry is also different in the health care system. In a true "market" the only barrier to entry is one of money or ideas. In health care, however, providers face licensure requirements, as well as myriad other government regulations.

Finally, traditional markets are supposed to create a financial stake for their participants. That approach is approximated in health care as "managed care," wherein providers are put at risk of losing reimbursement for "unnecessary" procedures. As is well known to all, however, Americans find "managed care" unacceptable. They are quite vocal in their opposition to participating in health care where their providers have a financial interest in the outcome.

That said, there are clearly some opportunities for elements of the market to be part of the delivery and financing of health care. Empowering consumers through information, as well as through measures of accountability, can and should be, fostered whenever possible. Providers should be encouraged to compete on price and quality for business in those service areas where consumers can reasonably make decisions.

Insured medical care is only one part of health care. As noted above, concerns as to the availability and affordability of medical insurance led the governor to create and charge this commission. However, we came to learn and appreciate that insured medical services represent only one, albeit important, part of a health care system that touches Maine citizens in many and often subtle ways.

Within the broad context of health care, policymakers must consider Maine's investments and policies with regard to:

· Environmental Health. The state of our water, our air, and our soil critically affect the health of our

communities. Environmental factors, both natural and man-made, contribute to diminished health status and increased costs. Lead-based paint, polluted water supplies and soil, increased exposure to chemicals of all kinds: all have serious negative impacts on a community's health. Developmental sprawl is another culprit; an increase in vehicle-miles-traveled has meant an increase in smog and a corresponding increase in certain debilitating health conditions.

· Public Health. Immunizations, food handling, sanitation, school health, alcohol and tobacco education, and community clinics might be all considered within the domain of the state's public health system. In some cases, that system provides services to uninsured populations who would otherwise do without. In many other cases, public health services complement the activities of the insurance-based health care system.

· Family Supports. Much of the care provided to the elderly, disabled, and children is provided through families. While generally considered to be "free" services, they do have costs: time lost from work as well as the constraints imposed on caregivers.

Within an even broader scope, issues related to public safety, parks and recreation, housing, nutrition and education affect a community's health costs—and extend beyond physician and hospital services.

Government plays an enormous role in how health care is provided and financed. While the state's role is not insignificant, the federal government is the dominant player. The Medicare and Medicaid programs offer insurance coverage to nearly one in three Maine residents. That population accounted for more than one-half of the 1999 personal health care expenditures in Maine.

Federal programs have undergone tremendous change in the last few years, driven by changes in national public policy. On one hand, they have put forth new initiatives such as the Medicaid expansion for children, known in Maine as Cub Care. On the other, faced with mounting costs, and under the mandate of the Balanced Budget Act of 1997, federal reimbursement to Maine hospitals has been especially problematic. In the private insurance market, federal regulations, as they apply to companies that have self-insured arrangements, preempted state laws and effectively put such schemes outside state control. Finally, federal support for medical research and education is a significant force in both the public and private sector.

Given the particular role of the federal government, some conveyed to the commission that the debate about a national health care program is moot: the nation is almost there. Others noted the reverse: it is government's involvement in financing health care that has caused many of the today's health care problems.

What is clear to the commission, however, is that the federal government is an integral player— and will continue to be. Decisions made in Washington as to who receives services, how those services are provided, and how much is paid for them, profoundly affect the costs of health care financed by state government, by private employers, and by consumers.

The employer-based system of health care is under tremendous pressure, and may be at risk of failing. Nearly 60 percent of Maine's citizens have some of their personal health expenditures covered under an employer-based insurance program. The degree to which the United States relies on private employment for health insurance is unique to this country, and is facing significant problems.

As discussed later in this report, cost shifting by government and uninsured groups, as well as consumer demands for unimpeded access and comprehensive coverage, are placing enormous pressures on the private insurance system. Those pressures are typically manifested in the form of cost increases significantly larger than increases in other business expenses. Given present labor shortages, however, employers are reluctant to reduce medical benefits or require higher employee cost sharing. But should the economy soften, many experts predict that health care benefits will be the first cost-cutting priority. Indeed, some national companies are questioning the underlying structure of their commitment to medical benefits. Instead of a defined benefit approach, they are suggesting a fixed financial health care com-

mitment to their employees. Employees, in turn, could use that set amount to identify and purchase health insurance on their own.

It is very difficult to accurately sort out price, charge, and cost for health services. Traditionally, cost is the amount it takes to develop, produce, and sell a product; price is the amount a consumer must pay to purchase that product. In the realm of health care, however, there is no generally accepted financial *lingua franca*: the terms cost, charge and price have no clear meaning. They are affected significantly by many factors: government reimbursement, charity care, and write-offs, for example. There is often no real relationship between the actual costs of health care provided to the prices that are ultimately charged for it and ultimately to the reimbursements that are made to providers.

Cost shifting is varied and pervasive. Typically, cost shifting refers to situations in which low-income individuals receive charity or low-cost care from physicians or hospitals, care covered by higher costs paid by those financially better off—or with better insurance: a clear case of the rich subsidizing the poor. It also refers, however, to cases where higher-income individuals pay for their health care with pre-tax dollars or employer-based insurance, options not open to all. In such cases, it is the less advantaged who are doing the subsidizing. Furthermore, reducing monies available for charity care increases the burden on the poor. Finally, large corporations have considerable leverage in purchasing insurance for their employees, which results in lower costs to them, and often to their employees. Thus the cost to a patient can vary dramatically, depending on whether she is poor, whether she works for a large or small employer, and whether she purchases her insurance on her own.

Much of what's wrong with our health care system is reflected in the uninsured population. There is, justifiably, a great deal of attention focused upon the uninsured and underinsured.[4] Health care provided to those groups is often too late, fragmented, episodic and expensive.

Based on different sources, the commission learned that in Maine:

· 34 percent of the uninsured report never having had health insurance of any kind; seven percent of the currently insured population reported not having any kind of health insurance for six months or more within the last three years.

· 71 percent of uninsured adults are employed on a full or part-time basis. 40 percent of the uninsured earn between $10,000 and $15,000 a year; five percent earn more than $50,000 annually.

· Adults most likely to lack health insurance are between the ages of 19 and 34 years of age, and 53 percent of them are male.

· With approximately 15.7 percent of its 18-64 population uninsured, Maine ranks 25th in the country, but highest in New England.

Nationally there is good evidence that care for the uninsured is sub-optimal. 30 percent of the uninsured do not fill prescriptions because of the cost[5] and uninsured individuals are three times more likely to die in the hospital than the insured.[6]

And while cost shifting is clearly a phenomenon, tightening reimbursement policies by government and private payers are creating less flexibility for providers in their pricing and in turn contribute to making health care even less affordable to those in need.

Many Mainers hold fundamental—and incorrect—beliefs about their own health and their health care system. Contrary to popular opinion, however:

· Maine residents are less healthy than other Americans: we smoke too much, exercise too little and do not eat well.

· Maine's population is older than average, and its proportion of elderly is expected to continue to exceed that of other states.

· All Maine's children do not have health insurance. Approximately 18,000 children still lack coverage.

· Maine does not spend more than other states on all aspects of health care than do other states. Expenditures for prevention and public health are lower in Maine than in the rest of the country. The state's emphasis is on medical treatment, not consumer behavior or preventative programs.

· A national, single payer system may be the only approach that will work to control costs, assure access and rationalize the delivery of health services.

We believe that this report can serve as the foundation for sound health care policymaking in the future. It is designed to be the basis of a long-term strategy, not merely a presentation of quick and easy "fixes."

[1] See inside front cover for brief biographies of the commission members.
[2] Steven R. Michaud, Maine Hospital Association, presentation to the commission, March 13, 2000.
[3] National Institute for Health Care Management, NICHM Health Care System DataSource, 1999.
[4] For purposes of this report, the term "underinsured" refers to those individuals who have only catastrophic health insurance, i.e., policies that take effect only when some high personal deductible—typically $5,000 per year—has been reached. Such policies are, of course, better than no health insurance at all, but individuals covered by them often cannot afford preventive care.
[5] *Consumer Reports*, "Second Class," September 2000.
[6] American College of Physicians and American Society of Internal Medicine, *No Health Insurance? It's Enough to Make You Sick.* www.acponline.org.

Chapter 2
COST PROFILE

Introduction

This is the centerpiece of the Commission's work: a thorough analysis of who spends what money for what services in what categories of health care in Maine. Its focus is upon personal health expenditures: those goods and services associated with direct prevention and cure of disease, as well as treatment of physical injuries. It comprehensively estimates the cost of personal health care in the state, and identifies factors contributing to those estimates.

The chapter estimates 1999 personal health expenditures for the citizens of Maine across five population subgroups, broadly defined by their primary insurance programs, and according to eight major categories of services that parallel reporting schemes adopted by the U.S. Office of the Actuary, Health Care Financing Administration (HCFA). Also discussed are indications of geographic variance in costs, the nature and impact of cost shifting, cost drivers, and recommended areas for additional and future investigation, analysis, and refinement of personal and total health care costs in Maine.

Findings of this chapter indicate:

· Health care is a large part of the state's overall economy: one out of every seven dollars spent in Maine is related to health care. Expenditures covered by federal dollars under Medicare and Medicaid are very significant and represent "imported" revenue; that is, money coming into Maine from away.

· The largest service expenditures are for institutionally based services, namely hospital care and nursing home care. Those two service categories represent 50 percent of all non-administrative expenditures.

· Cost shifting can have dramatic impacts. While the degree of cost shifting by Medicare as a result of the Balanced Budget Act was not independently confirmed in this study, it is clear that any reductions in federal expenditures not absorbed by providers will represent significant increases for other payer groups. In regard to the uninsured, cost shifting has been estimated to be on the order of $160 million in 1999.

· Health care expenditures have increased—and will continue to increase—at a faster rate than other goods and services. Expenditures related to pharmacy services and other personal health care are projected to represent the largest contributors to future increases. As a result, health care will be an increasingly larger part of Maine's economy.

· Health care costs vary geographically. These variances are due to local competition—or lack thereof—and local community planning, as well as to service volume. The latter factor may be particularly significant in rural locations where hospitals often maintain under-utilized infrastructure.

· Expenditures related to administering insurance claims are significant—and represent only one part of the non-clinical overhead costs of providing services in Maine.

· Other states share many of the same issues and challenges with Maine.

Personal Health Care Expenditures

Approach

This study uses a population-based, rather than program-based, approach. That is, personal health expenditures are reported for major populations groups as defined by predominate insurance arrangements. Those expenditures include insurance payments, as well as out-of-pocket expenditures for services and insurance premiums. For example, Medicare (excluding persons who also had Medicaid insurance) covered approximately 173,000 Maine residents in 1999. While it was the principal insurance program for those individuals, they incurred expenses beyond those covered by Medicare. Such expenses include, but are not necessarily limited to, pharmacy costs, co-payments, and deductible expenses, which may have been covered by supplemental insurance programs or paid directly by the beneficiary. The reported estimates for personal health expenditures include all those different amounts.

Total personal health expenditures were tabulated from actual claims experience, supplemented by survey and other information that permitted approximations for each identified population.

Finally, the approach of this study differs from the one used by HCFA, which is based on estimates of provider receipts from different payment sources—and considers out-of-pocket expenses as a single, combined payment source. As a result, HCFA does not report such expenditures by specific population groups.

Limitations

In reviewing the data and findings, a reader must consider a number of limitations.

· Aggregated data and findings are the most valid. The greater the specificity in terms of population and service category, the less valid the data.

· This study estimates personal health expenditures for calendar year 1999. Although data were collected for the most recent period available, in many instances it was necessary to extrapolate available information from earlier years to 1999.

· The health care market is very dynamic; it has a constant inflow of new—and sometimes contradictory—developments. For example, the study reports an uninsured population of approximately13 percent of the total population. Anecdotal information indicates that number has increased in recent months, particularly in the small group and individual markets as a result of increasing insurance premiums, and decisions by a number of carriers to leave the state.

In late September 2000, however, the Census Bureau reported a large decline in uninsured Americans, noting that the strong employment economy was positively affecting the number of persons provided health insurance through place of work. For Maine, the bureau estimated an uninsured rate of nearly 12 percent in 1999, and a three-year average uninsured rate of slightly more than 13 percent.

While troublesome, the material impact of those discrepancies is thought to be small within the context of total expenditures, and of the application of the information to broad policymaking in Maine.

· Whenever available, data specific to Maine were utilized. For example, the study uses Medicare and Medicaid data, as well as a significant proportion of the private insurance information, specific to recent Maine experience. When state-specific information was not available, the study relied on national data and experience. That is particularly true for estimated personal health expenditures related to the uninsured population.

· There is an underreporting of expenditures incurred in certain service locations and among certain populations, i.e., public health clinics, school care programs, prisons, veterans programs, and the Indian health services.

· Dental services are not included in this profile. While HCFA identifies dental care as an explicit service category in its inventory of personal health ex-

penditures, sufficient data, particularly for persons with private insurance, were unavailable. Private dental insurance is typically underwritten separately, and there are no indications that the availability of dental insurance has been materially affected by recent turmoil in Maine's private insurance markets.

· Detail with regard to important services and costs are often masked in aggregate data. For example, personal expenditures for mental health services are included within **Hospital Care**, **Physician Services**, **Other Professional Services**, as well as other categories. It is, however, not possible to segregate such expenditures for separate analysis.

· Personal health expenditures do not include very significant indirect subsidies. For example, employer-sponsored health insurance programs enjoy preferential tax treatment to the extent that the cost of the benefit represents tax-free compensation to employees. Similarly, the nonprofit status of all Maine hospitals and many other health care organizations creates a subsidy funded by other taxpayers.

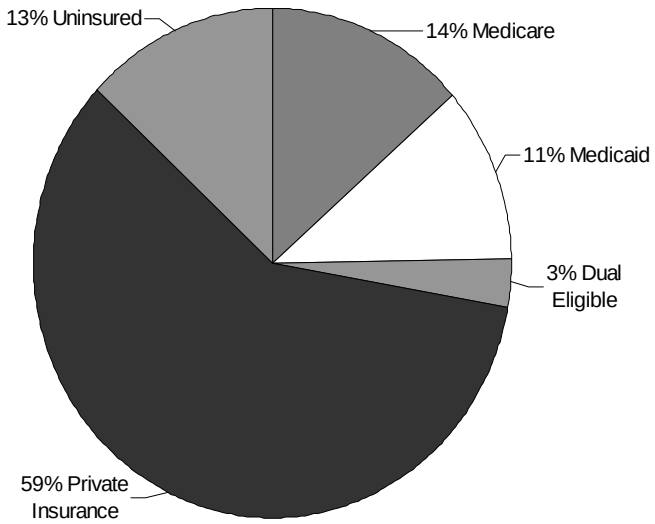
· Finally, informal and usually free care, including that provided by family and friends, is not included in the estimates. A recent survey by the Maine Development Foundation determined that 14 percent of the respondents were helping care for an older family member and 10 percent for someone with a disability or disease.[1] The median commitment for the former group was reported to be between five and 10 hours per week, more than 11 hours per week for those caring for someone with a disability or disease. Moreover, the survey reported that 12 percent of the respondents routinely took time off from work to care for an elderly person. Clearly, those informal services would represent very real additional costs if compensated providers were utilized.

Findings

For Maine

Figure 1 shows how Maine's population breaks down by insurance program: Medicare recipients; Medicaid recipients; those beneficiaries who have both Medicare and Medicaid insurance (the term "dual eligible" is used to refer to such individuals); those who have private insurance; and uninsured citizens. (See also Table 1 in Appendix A)

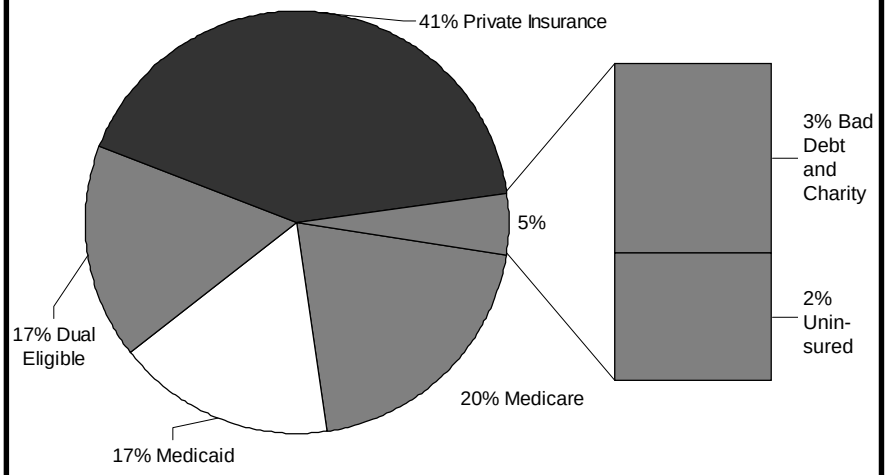
Figure 1
Estimated % of Total Population In Maine By Population Groups (1999)



The recent Maine Development Foundation survey also identified some characteristics of the uninsured. They had lower incomes than the insured, for example: 78 percent reported incomes of less than $35,000 per year. While 63 percent of the uninsured had an educational level of high school or less, one third reported college education. Respondents with a community or technical college education were most likely to have insurance (only three percent of that population indicated that they were not currently covered by a health care plan).

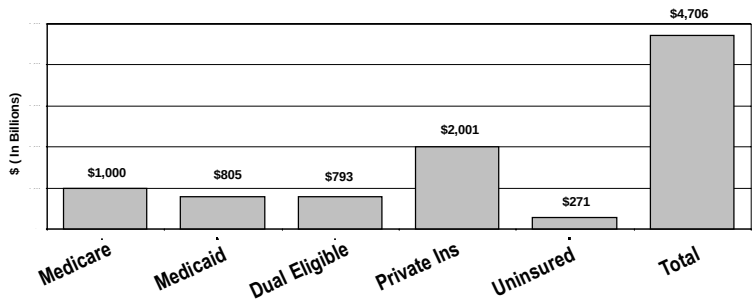
The most frequent reason given for not having insurance was high premium costs (66 percent). While 20 percent of all respondents reported that their employer did not offer a sponsored health insurance plan, only 11 percent of those uninsured noted that as the reason that they do not have coverage.

Figure 2
Estimated Percent of Total Personal Expenditures By Population Groups In Maine (1999)



Note: Bad debt and charity amounts are implicitly included in Private Insurance, which increases to 43%.

Figure 3
Estimated Total Personal Expenditures By Population Groups In Maine (1999)



Note: For the uninsured, the amount reported in this chart represents the total personal health expenditures. Actual amounts expended directly by the population are estimated to be about $107 million. The difference between those two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other populations (particularly those with private insurance). In order to avoid a double count, the total reported above includes only the estimates for actual expenditures by the uninsured.

A recent survey by the Muskie School of Public Service reported additional insights specific to uninsured children (age 0 through 18 years).[2] The number of Maine children without health insurance is estimated to be nearly 18,100. Approximately 11,000 of those children reside in households with incomes that are less than 200 percent of the federal poverty levels, and therefore would be eligible for either Medicaid or Cub Care. In those cases, the problem is not lack of access to coverage, but that their parents have failed to enroll them. The remaining 7,000 children represent approximately two percent of all children through age 18.

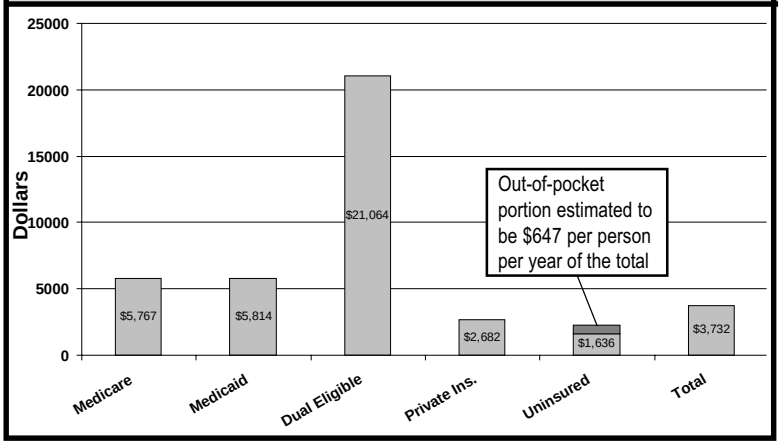
As Figure 2 shows, personal health expenditures by persons covered primarily by a publicly funded insurance program, Medicare and Medicaid, represent more than 50 percent of the total expenditures in the state. That amount is even greater if private insurance programs for state employees, public school teachers, municipal workers, and state university employees are included. Contrary to common understanding, possibly 60 percent of all expenditures are grounded in programs supported by public money.

The coverage and reimbursement policies adopted by Medicare and Medicaid have immense implications for the financial viability of provider groups, as well as for cost shifting to persons insured primarily through a private plan. Hospital administrators in Maine claim that Medicare shortfalls are in the amount of $100,000,000 per year.[3] To the extent that claim is valid, those shortfalls are either absorbed by institutions or shifted to other payers, principally those persons with private insurance.

As Figure 3 shows, estimated personal health expenditures of all groups totaled about $4,706 billion, representing nearly 14 percent of Maine's gross state product. That figure stands in contrast to the U.S. where it is estimated that personal health expenditures represent 12.3 percent of the gross domestic product.[4]

As shown in Figure 4, per-person expenditures on health care range widely, from a low of $1,636 for the uninsured (actually, $647 per-uninsured person after charity care and write-offs for bad debts are considered) to a high of $21,064 for dual-eligible beneficiaries. (See also Table 2 in Appendix A.)

Figure 4
Estimated Per Capita Personal Health Expenditures By Population Groups in Maine (1999)



For persons with either Medicare or Medicaid coverage, personal expenditures are similar: approximately $5,800 per person in 1999, or slightly more than twice the expenditures of those persons with private insurance (nearly $2,700). That is not surprising. The higher morbidity associate with age, poverty and/or disabilities (all conditions associated with eligibility for either Medicare or Medicaid) will have higher accompanying expenditures.

Expenditures for persons with *both* Medicare and Medicaid are more than three and one-half times greater than persons with either Medicare or Medicaid alone. Approximately 70 percent of the combined amount is covered by the Medicaid program. While most of the dual-eligible beneficiaries are the frail elderly, adults with significant disabilities are also included. More than half the expenditures for that population is associated with **Home Health Care** and **Nursing Home Care**, reflecting the significant utilization of long-term care services.

Personal health expenditures for uninsured Maine citizens are estimated to have totaled about $271 million, or $1,636 per person, in 1999. The actual amounts paid for care by the uninsured totaled $107 million, or nearly $650 per person. Out-of-pocket expenditures by the uninsured are highest for physician and pharmacy services. Approximately 60 percent (or more than $163 million annually) of personal health expenditures incurred by the uninsured is estimated to be "covered" under charity and bad debt provisions made by providers.

Notwithstanding the above estimates of charity and bad debt, estimates for the uninsured suggest a lower rate of expenditures than those made by the privately insured. That difference may be attributable to two factors: the cost of health care prevents the uninsured, as well as the underinsured, from seeking services; or more-healthy populations with lower expenditures voluntarily decline insurance coverage. The latter population appears to be small. Only five percent of those respondents without health insurance reported in the Maine Development Foundation survey that they were healthy and did not feel they needed coverage.

Based on a recent Market Decisions survey, it appears that uninsured Mainers do receive hospital care. The report notes: "hospital care is not deferred because of a lack of health insurance."[5] That observation is consistent with our findings that estimates of personal health expenditures for hospital care are approximately equal to the amount that hospitals report for charity and bad debt. In other words, the uninsured go to hospitals when they perceive a need, but costs associated with such utilization are largely written off as bad debt or charity care.

Figure 5
Estimated Percent of Out of Pocket Share of Personal Health Expenditures in Maine (1999)

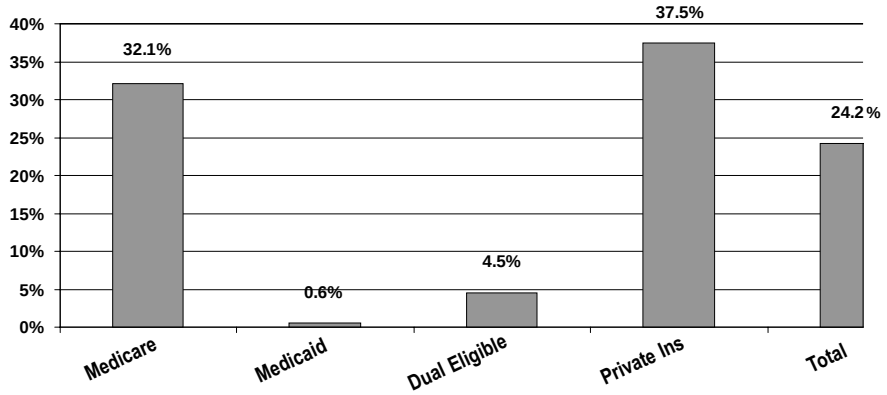
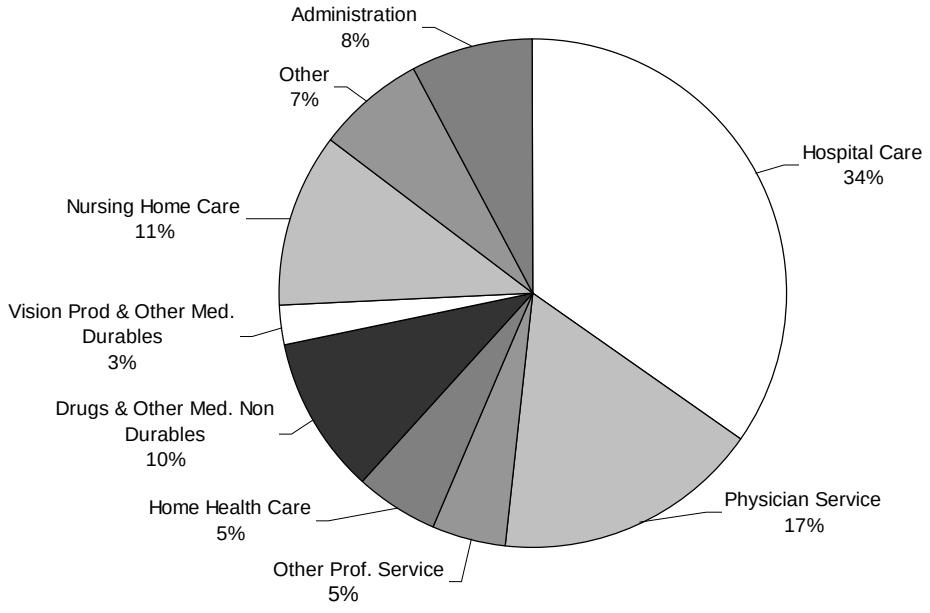


Figure 5 shows that the amount of personal health expenditures directly paid out-of-pocket by individuals also varies widely. Excluding the uninsured, out-of-pocket expenses include direct contributions to health insurance premiums, cost-sharing provisions at the time services are rendered, and expenditures for services not covered by an insurance program. In 1999, out-of-pocket expenditures averaged about 24 percent, and ranged from a high of 37.5 percent for those with private insurance to less than one percent for those covered principally by Medicaid. (See also Table 3 in Appendix A.)

Those estimates correlate reasonably well with survey information provided by Market Decisions. Survey respondents reported that the median percent of personal health expenditures paid out-of-pocket was 20 to 29 percent. In terms of dollars, the median response was in the range of $1,000 to $1,999.[6]

Figure 6 reports the personal health expenditures in Maine according to major service categories. While providing some insights, the categorization provides little information as to personal health expenditures based on care needs. For example, it is not possible to identify personal health expenditures related to behavioral diagnosis. Such expenditures are included among different provider types.

Figure 6
Estimated Percent Of Total Personal Health Expenditures By Service in Maine (1999)



Since 1994, as shown in Figure 7 and Figure 8, health care costs in Maine have increased faster than the consumer price index. (See also Table 5 in Appendix A.) The largest increase has been in **Drugs** and **Other Medical Non-Durable Services**. As the figures also show, total annual personal health expenditures (without **Insurance Payer Administration**) are estimated to almost double in ten years, to nearly $8 billion. The service categories estimated to increase the most are: **Home Health Care**, **Drugs and Other Medical Non-Durable Services** and **Other**. In contrast, **Hospital Care** and **Physician Services** are estimated to make relatively modest contributions to future personal health expenditures.

Figure 7
Estimated Total Personal Health Expenditures in Maine for Select Years (without Insurance Administration)

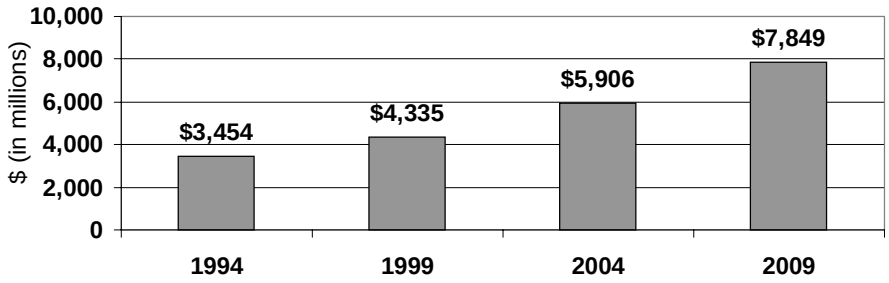
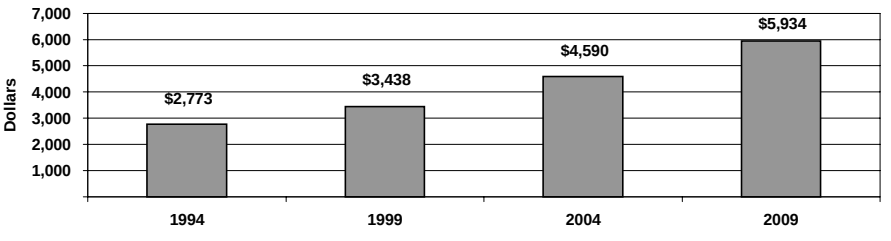


Figure 8
Estimated Per Capita Personal Health Expenditure in Maine for Select Years (without Insurance Administration)



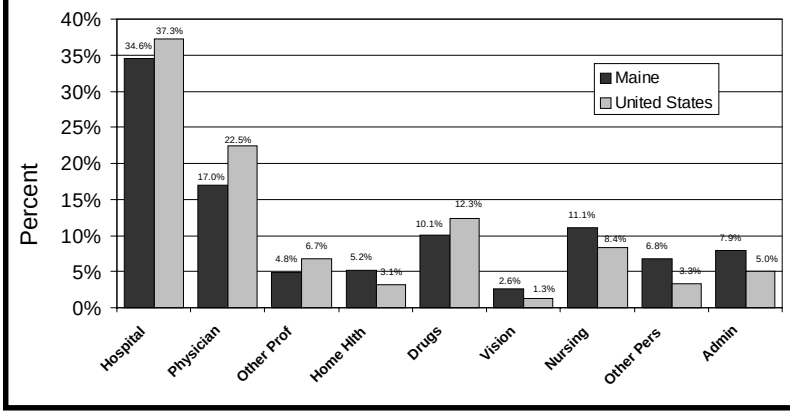
Notwithstanding the magnitude of the expenditures reflected in the projections, they do not include the impact of aging baby boomers. That population begins to reach age 65 in 2011, and will further accelerate increases in health care expenditures in subsequent years.

National Comparisons

As mentioned earlier, about 12.3 percent of the national gross domestic product is spent on health care, whereas the amount in Maine is about 13.9 percent. The difference between Maine costs and U.S. costs relative to GDP reflects, in part, the smaller Maine economy. Still as a measure of relative priorities, Maine devotes a larger share of its gross domestic product to health care than does the country as a whole. A comparison of the actual costs, however, looks very similar: health care spending in Maine is about $3,732 per person (including insurance administration), while U.S. health care spending is about $3,798.

As Figure 9 shows, the distribution of health care expenditures for Maine and the United States varies notably among service categories (See also Table 2 in Appendix A). As a percent of total expenditures, Maine's allocation to **Home Health Care**, **Vision Products** and **Other Medical Durables, Nursing Home Care**, **Other Personal Health Care** and **Insurance Payer Administration** is larger than that of the United States. The proportionally smaller allocations for **Hospital Care** and **Physician Services** in Maine, as compared to the nation, are noteworthy.

Figure 9
Per Capita Estimates of Personal Health Expenditures, by Services, Maine and USA (1999)



Interstate Comparisons

Figure 10 compares Maine's costs with those of North Dakota, Wyoming, West Virginia, and Vermont: states identified by the State Planning Office as similar to Maine in demographic and income characteristics (See also Table 4 in Appendix A.)

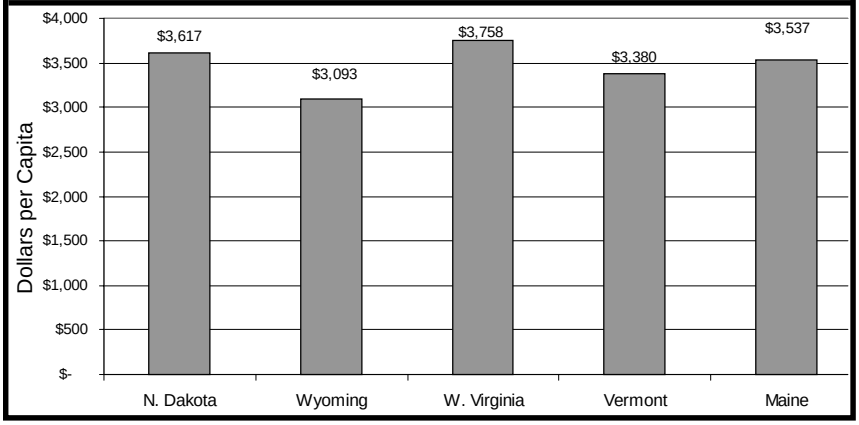
The percentage distribution of personal health expenditures in Maine is generally consistent with other, similar states. The same can be said for total personal health expenditure as measured by dollars. There are some exceptions, however. **Hospital Care** represents a smaller percent of personal health expenditures in Maine. To a lesser extent, the same can be said for **Physician Services** and **Other Professional Services**. In contrast, **Nursing Home Care** represents a larger percent. (While expenditures for **Nursing Home Care** in North Dakota are similar to those of Maine, the similarity disappears when **Nursing Home Care** is combined with **Home Health Care**). These findings parallel the comparison of Maine to the entire United States.

In 1999, the Maine Health Data Organization sought to examine geographical variations with Idaho, a state demographically similar to Maine.[7] The two states have almost identical populations, 1.2 million, though Idaho has a larger land area. Personal income is similar, the gross state products are almost equal, and the mix of occupations and business types is also close. Neither state is racially diverse: both are almost entirely white. One key difference is that Idaho has a larger proportion of young people—32 percent under age 20, as opposed to Maine's 26 percent—and a smaller elderly population. Some 11 percent of Idahoans are older than 65. Idaho's median age is 33, while Maine's is nearly 37. Those age differences have a significant impact on differences in utilization patterns.

The overall health ranking averages of the two states are similar, but there are also significant differences. Maine has a lower infant mortality rate, one of the lowest in the country, as well as a higher immunization rate. On the other hand, its cancer rate is the third highest in the nation. Idaho has low chronic disease and death rates. Hospital wages are quite similar, as are the costs of practice for physicians.

In the broadest national index of hospital spending, Maine's cost per capita is slightly above the national average ($1,159 against $1,143), but Idaho's is much lower, possibly the lowest in the nation.

Figure 10
Estimated Per Capita Personal Health Expenditures among Comparative States for 1999 (without Insurance Administration)



A detailed comparison shows the reasons for the striking differences in hospital costs.

· Although the two states have about the same number of hospitals of similar sizes, Maine has far more hospital beds and physicians, leading to annual revenues about one third higher.

· In 1996, Maine had 3,407 hospital beds, while Idaho had 2,736.

· There were 3,365 full-time registered nurses at work in Maine hospitals, 2,274 in Idaho.

· The number of surgeries was about 25 percent higher in Maine.

· Although the two states had roughly the same number of general or family practice physicians, Maine had far more specialists. In other studies, specialists have been shown to be far more aggressive in the treatment of various ailments than general practitioners, ordering greater number of tests and procedures and performing surgery more often.

As various observers of the Maine-Idaho study have pointed out, the results do not necessarily mean that Maine has too many hospital beds or physician specialists. And it is possible that Idaho residents receive their hospital care out-of-state. In addition, Idaho has publicly funded county hospitals, while all of Maine's hospitals are community-owned, private, nonprofit entities. Nonetheless, the comparison is useful in considering the questions of how much care is needed in what settings, and whether there are possible alternatives for hospitals to consider.

Intrastate Variations

This cost profile does not fully consider price and cost variation within Maine but there are, however, a number of indications that the variance between rural and non-rural areas in Maine is considerable. Rural hospitals have a larger proportion of Medicare and Medicaid patients—payers that, according to interviewees, reimbursed hospitals at lower rates than are needed to cover costs.[8] In addition, those institutions have more limited labor pools, which may increase salaries, and thus cost in general. According to Market Decisions, there is also some indication that smaller hospitals have a larger number of uninsured patients.[9]

Maine's geography also has a powerful effect on health care prices. A recent study detailed the size of Maine's hospitals in relation to their service areas.[10] Intuition would seem to dictate that the number of hospital beds in any given area would be closely related to the number of people its hospitals serve. That is not the case, however: Maine hospitals have as many as 663 people in their service areas for each licensed bed and as few as 214: a greater than three to one variance. Population concentrations, or availability of acute care, did not affect that variance: among small group hospitals doing mostly routine procedures, one hospital has 613 people per bed in its service area, another just 223 people per bed. Hospitals, however, typically have more licensed beds than beds that are actually staffed at any given time.

Furthermore, there is much scientific and anecdotal evidence that where there are more doctors and more hospital beds in relationship to the population, there are higher rates of medical procedures. In 1980, it was found that in one area of Maine, women were twice as likely to have a hysterectomy as those living elsewhere.[11] In 1983, three new surgeons in one area collectively performed more than 60 percent more back surgeries than otherwise would have been expected.[12] And in 1999 twenty-one percent of Maine births took place through Cesarean sections, a percentage higher than the national average, which most health experts agree is itself too high.[13]

Estimates related to the possible state authorization of six additional catheterization facilities bear out those findings. If normal utilization rates were to be met at all those locations, Maine would probably have the highest rate of cardiac catheterization, angioplasty, and open-heart surgery in the nation, even though no extant data confirm a need for that level of surgical procedures. In such cases, "improved access" would not seem to lower the costs—or better the outcomes—of health care. The commission is not suggesting that Mainers should be required to travel long distances to obtain quality care,

or that new catheterization facilities would not improve health care in the state, merely that duplicative efforts do not typically lower the overall costs of obtaining such care, and that hospital costs are generally greater at smaller and more rural locations.

An analysis of Medicare cost and charge data revealed regional differences between northern Maine, southern Maine and the greater Boston metropolitan area.

Figure 11
Margin between Hospital Charges and Costs

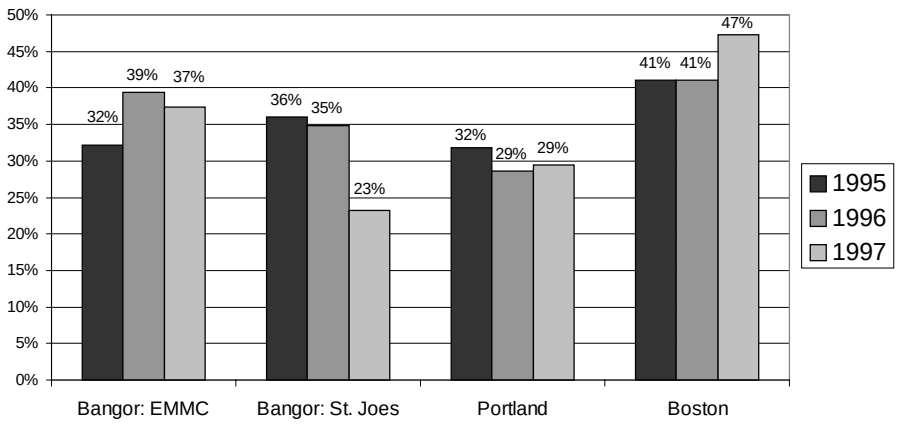
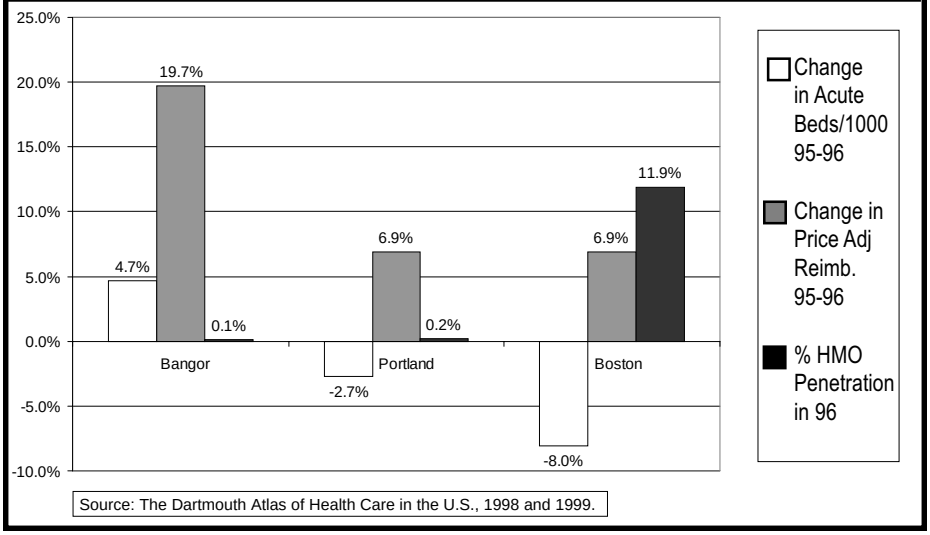


Figure 11 reports the difference between charges and costs as reported for Medicare beneficiaries for 1995, 1996 and 1997. Those margins are clearly largest in the Boston region and may, to the extent the data can be extrapolated to other payers, explain the larger discounts that managed care companies indicate they enjoy in Boston. Over the three-year period, Portland hospitals reported the lowest margin. Overall, the data indicate some geographic differences in hospital charges as a function of costs, at least for Medicare beneficiaries.

Changes in bed capacity, price-adjusted reimbursement for Medicare beneficiaries, and HMO penetration are reported in Figure 12. In both Portland and Boston, the total number of acute care beds (per 1000 population) declined between 1995 and 1996. The opposite was true in Bangor. Price adjusted reimbursements for Medicare increased less than seven percent in Portland and Boston, nearly 20 percent in Bangor. Finally, HMO penetration in Bangor and Portland was virtually nonexistent in 1996, as compared to nearly 12 percent in Boston.

For Boston, the data suggest that increases in Medicare reimbursement, as measured by HMO penetration, were moderated by an increasingly competitive marketplace. In response to less demand, Boston hospitals also reduced capacity, although it may be argued that they had excess capacity at the start of the study. None-the-less, that appears to be an instance where a competitive market worked as predicted: less demand resulted in lower prices and reduced supply.

Figure 12
Hospital Capacity, Medicare Price Adjusted Reimbursement and HMO Penetration



During those same years, in contrast, Portland experienced voluntary downsizing via hospital mergers. Rather than competition, Portland hospitals were attempting voluntary, community planning. Interestingly, that approach seems to have been as effective as Boston's competition.

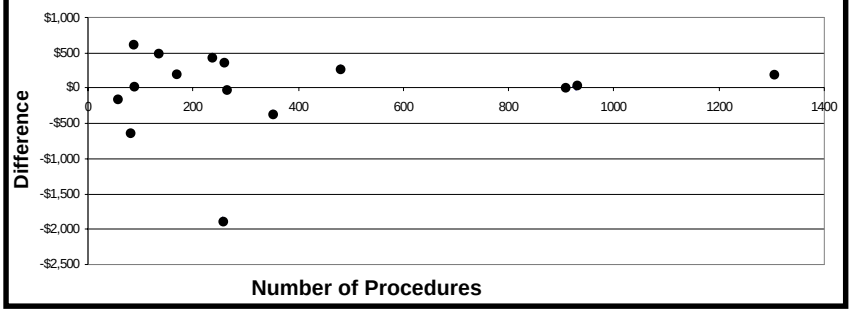
As measured by those indicators, neither a competitive nor planning model appeared to be at work in the Bangor region. That conclusion may still be valid. Based on total per-member, per-month costs for the twelve-month period ending June 2000, one insurer's experience in the Bangor market was that charges there were 35 percent greater than in the Portland market.

Service volume is an important cost factor, in addition to geographic variation. Because fixed costs represent such a significant portion of a hospital's overall cost structure, institutions with a larger-than-needed capacity may have higher costs. It follows, then, that hospitals in rural locations with smaller populations and service needs may have higher costs. Figure 13 supports that conclusion. The data indicate that hospital charges of low-volume (i.e., smaller) hospitals are more variable, and frequently higher, than those of larger institutions.

There are, however, caveats in that analysis. Charges do not necessarily equate with actual reimbursements and the "expected" charges are strongly influenced by the large volume hospitals. As Figure 14 indicates, the correlation between volume and charges was much less variable for normal births. Here issues of case-mix and other factors do not play an important role. The analysis does provide some evidence that for certain conditions and procedures, small hospitals may be more costly than larger facilities.

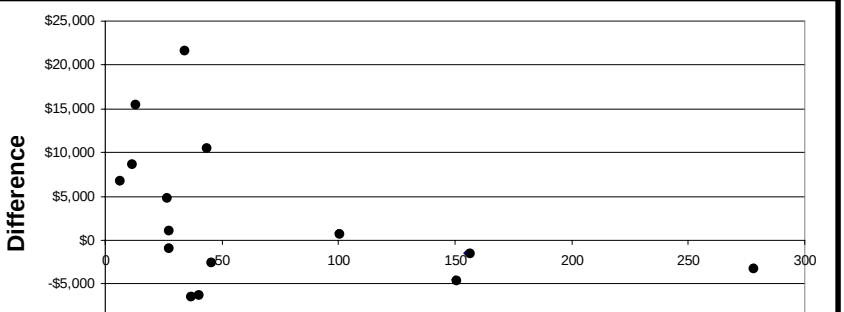
Hospitals in Maine vary significantly in charges for surgery even when adjusted for case mix. While small volume hospitals are more likely to charge more than large volume hospitals, there are exceptions in Maine. The average charges of two out of eight large hospitals are well above expected charges while charges of nine out of thirty small hospitals are below expected charges.

Figure 14
Actual vs Expected Charges for Vaginal Deliveries w/out Complications
(Select Hospitals, 98-99)



Taken together, all the data in this section indicate that geographic variances, particularly as they affect service volume, appear to be an important contributor to cost differences within Maine.

Figure 13
Actual vs Expected Charges for Major Bowel Procedures
(Select Hospitals, 98-99)



Cost Shifting

There is little consistency among what is paid by individual consumers for medical services. Neither is there consistency among the cost, price and charge for health care services. Like an airline flight comprising 78 passengers who each paid a different amount for passage, health care has nearly as many "prices" as it has people participating in the system. Not surprisingly, those inconsistencies have led to confusion and uncertainty as to the "real" cost of a medical service, as well as to a complicated patchwork of cost shifting between and among various payer groups.

Furthermore, it is impossible to determine if the costs paid by a patient accurately reflect the costs of delivering services. Although hospitals may engage in serious cost accounting, there are a number of additional elements that factor into what they actually charge. For instance, hospitals are guided by the prospects for reimbursement and expected levels of reimbursement from both government and private insurance programs.

The fact that large employers can negotiate smaller fees for the insurance they provide to their employees means that individuals who purchase their own, more expensive, health care incur more than their "fair share" of costs. Medicare and Medicaid payments have also been criticized as shifting costs from one population to another. Medicare reimbursement rates to Maine service providers are among the lowest in the country. Hospital administrators identified that as the most important cost-shifting factor—on the order of $100,000,000 annually.[14] Providers also fault Medicaid, which includes both federal and state funding for not paying its fair share of the costs of health services.

To the extent that Medicare and Medicaid fall short in paying rates in line with costs, the impact is significant. Because they pay more than half the health care bills in Maine, any shortfalls by the programs require providers to either reduce their costs or shift the shortfall to other payers with less purchasing clout: typically, private insurance programs or individuals who pay directly for services.

The political and regulatory policies for cost shifting by Medicare, and to a lesser extent Medicaid, are beyond Maine's ability to control. The issue reflects the tug of war between federal and state initiatives and priorities to meet a variety of social needs, to contain budgets and to respond to political realities.

Thus costs both increase for all and shift among and between segments of society sometimes borne by the rich, sometimes by the poor, sometimes by individuals, sometimes by governments. It is not surprising, then, that potential solutions primarily address the margins of the problem: the dilemma itself is almost too amorphous to define. Addressing the essence of the problem will require immense reserves of social and political capital, as well as heretofore-unknown collaboration among all the actors on the health care stage.

Cost Drivers

It can be argued that costs are not the problem. Rather, they are symptoms that reflect a variety of underlying causes, dynamics, priorities, expectations and, ultimately, contradictions.

In addition to identifying those facts that shift costs, testimony and materials provided to the commission identified a plethora of factors that drive costs. Unfortunately, many of those drivers will not be easy to fix. In some cases, they are largely outside the control of Maine or any other government jurisdiction. An aging population, for example, cannot be changed by government fiat. In other cases, solutions will require long-term and far-ranging social, political, and financial investments.

Use of Costly Procedures and Treatments

Consumer demand and knowledge factor into rising costs. The general public is much more knowledgeable about medical advances than it once was. Today's medical consumers insist on the "best, newest" treatments. For many, a long and healthy life is no longer an accident of fate but a right.

In fact, health care managers interviewed "theorize that the environment has become competitive due to consumers demanding access and services as never before." Furthermore, "consumer issues such as convenience, breadth of services, and depth of services, long limited to traditional consumer services, appear to be rearing their heads in the medical arena."[15]

Technological advances, while resulting in improvements in the delivery of care, also contribute significantly to increasing overall costs. If useful technology is available, it is difficult to deny it to a patient in need.

Utilization of medical services is largely driven by physicians. It is a doctor who orders a test, prescribes medication, makes a referral, admits to a hospital. That is particularly true in the case of elective medical care and procedures such as surgery and tests. Despite the fact that consumers know there are often alternative treatments for their conditions, and despite an increasing interest in shared decision making, physicians continue to exert a strong influence on the choices their patients make.

Thus physicians, along with their patients, need more comprehensive information about the cost-effectiveness and outcomes of alternative treatments for various conditions. When provided with reliable information about the risks and benefits of alternative treatments, patients will often opt for less complex and invasive treatments.

It is also clear that there are conditions for which utilization of hospital services is more strongly correlated with the hospital bed capacity available to the local population. Some have argued that where there is greater local capacity, patients will be admitted to the hospital for medical conditions that, in areas with less capacity, are treated in the ambulatory setting.

Rising pharmaceutical costs, fueled in large part by our increasing appetite for new and expensive drugs to treat a broad range of diseases and to improve quality of life, is a significant cost driver as well. In fact, consumers most often identified cost of drugs/prescriptions as leading the increase in Maine's health care costs.[16]

The desire of many hospitals and other health care facilities to attract consumers can also drive up prices. New services, however, often entail large capital investments that, in turn, must be recovered through high utilization. In such cases, supply induces demand.

Finally, while the commission is reluctant to identify advances in gene technology as a cost driver, there are indications that genetic mapping may lead to new possibilities for medical interventions, which has potentially serious cost consequences.

Lack of Consumer Concern about Price

Because much health care insurance amounts to prepaid health care services (that is, it covers many preventive and discretionary procedures) people are in effect insulated from the real costs of the care that they are receiving. They simply do not know how much many of their drugs, tests, and treatments cost. And because most of those who have insurance do not pay a significant portion of their health care expenses, they have no real incentive to choose cost-effective approaches. And even if they attempt to do so, they will find little or no link between expenditures and outcomes. Thus it is not surprising that most Americans know more about what it costs to run their automobiles than what it costs to keep them healthy.

In fact, when asked what information would be most helpful when choosing a health-care provider, only four percent of Mainers indicated the cost or method of payment, and only six percent indicated health insurance coverage as a factor. In contrast, measures of quality and reputation were listed by one-third of the respondents.[17]

Unhealthy Behaviors and Lifestyles

Avoidable consumer behavior contributes to higher costs in many cases. Use of tobacco, lack of exercise, poor personal safety decisions, and poor eating habits often contribute significantly to poor health status and increased health care costs. While individual decision making may be at the root of un-

healthy behaviors and lifestyles, these decisions are often made in the context of extremely limited choices and powerful influences beyond the individual's control.

It is likely that solutions to this cost driver are outside of the traditional medical system with its emphasis on curing illness and repairing injury. Rather, they reside within the broader context of health care. Examples range from mandatory seat belt and helmet requirements, to developing opportunities for exercise, such as urban trail systems linking parks and playgrounds, or swimming pools.

Emotion and Expectations

Finally, high emotion and unreasonable expectations often drive health care costs. Despite an intellectual understanding that no nation or state can possibly provide every possible health benefit to every citizen, individual Americans want their own family members to receive each of those benefits, regardless of cost. And while that may be in the best interest of those individuals and families, it is not necessarily in the best interest of society as a whole, contributing as it does to the increasing cost of health care.

Aging Population

In part, responsibility for increasing costs lies with the demography of the state's population. Like the rest of the country, Maine has more elderly people than it once did, but Maine's proportion of elderly in future years is estimated to be higher than in most other states. In a few years, for the first time in history, more of Maine's citizens will be older than 65 than will be younger than 18. That elderly population, naturally, needs more medical care than most other segments, which drives up overall costs. Those older than 75 are particularly costly, and that population is expected to grow relative to the population as a whole.

Administrative Inefficiencies and Programmatic Oversight

Maine's health care system is burdened by expensive, duplicative, administrative requirements. Using the PaineWebber calculation that 25 percent of health care expenses go to administration and waste; this implies that Maine spent more than $1 billion of its health care dollars in 1999 on administration and waste.

These inefficiencies were certainly highlighted by healthcare administrators interviewed by Critical Insights. Providing some very informal corroboration of the PaineWebber estimate, Critical Insights reports that estimates provided by hospital administrators vary "but anywhere from 15 percent to 20 percent of administrative time and/or costs tended to be the average estimate." Interviewees noted the growing administrative effort that is needed to comply with various business and medical management requirements imposed by payers: their perception being that the third party payer system achieves "cost savings by rejecting claims."[18]

Not surprising, insurance companies challenge those claims. Their representatives felt that many Maine providers, and particularly small physician-groups, exhibited a level of administrative inefficiency that included "unnecessary duplication of tests, inaccurate coding of procedures, paperwork that is incomplete or not completely properly, and lost records."[19]

Finally, human resource directors noted: "the complexity of the billing process for individual payers has geometrically increased, creating a similar increase in the number of forms required."[20]

Government Mandates and Regulatory Oversight

In addition to costs associated with administration of medical services, mandated benefits as well as regulatory activities (e.g., government protocols related to licensure, Certificate of Need), were noted by payers as well as providers as contributing to higher costs.[21] Of course, not all government mandates cost money, many of them actually save it.

In contrast to many of the other cost drivers, a significant number of mandates and regulatory oversight decisions can be addressed at a state level.

Poor Quality of Outcomes

Preventable medical errors add costs, as does a lack of continuity of care. As the health care system becomes more fragmented, diagnosis and effective, ongoing treatment becomes more costly and more difficult.

Environmental Factors

Environmental factors, both the natural and man-made, contribute to diminished health status and increased costs. In Maine, second hand smoke and ground-level ozone increase incidences of asthma and other lung disorders. Lead paint and asbestos have been shown to induce health problems in children. Lack of upper air ozone contributes to sun poisoning and increases the risk of skin cancer. And workplace injuries and illnesses remain a serious problem.

Further Research

The cost profile provides an important baseline and reference for policymakers and administrators in examining how Maine currently allocates health care resources, as well as how such allocations might be made in the future. As is always the case in studies of this nature, the data and findings create an appetite for additional and more detailed information. The commission hopes the data in this cost profile will provide a foundation for updates and refinement. Specifically, the commission believes that future study should be directed to:

· Including health care costs that were not addressed in this study. Those include, but are not limited to, mental health, dental care, Native American services, veteran's services, and school care.

· Developing a companion utilization profile that reports resource consumption in terms of diagnosis, hospital days, patient visits, tests completed and other service measures. Such data would begin to link cost and clinical information.

· Better understanding the composition of specific population groups, as well as the differential consumption patterns of each group. In addition to better examining the composition of populations, better differentiation of small versus large privately insured groups, populations with disabilities, and the frail elderly would provide valuable insights for the future.

· Better differentiating service categories. Those include but are not limited to: mental health and substance abuse services; secondary versus tertiary hospital services; primary versus non-primary professional services; and acute versus long-term care.

· Capturing more complete cost information from hospitals, physicians and other providers.

· Refining geographic differences within Maine, in terms of regional county groups and rural versus non-rural locations.

· Continuing the update, refinement and calibration of the estimates to reflect the rapidly changing health care marketplace, as well as new data sources. Doing so would mean an excellent historical record of changing cost and consumption patterns.

[1] Maine Development Foundation Annual Survey of Maine Citizens, November, 2000.

[2] Ormond, Salley, Kilbreth, "Health Care Access Project: Profiling the Uninsured in Three Maine Counties." Institute for Health Policy, Edmund S. Muskie School of Public Service, June 2000.

[3] Critical Insights, "Attitudes Toward Administrative Inefficiencies in Health Care," 2000

[4] The national percent is less than the often-quoted amount of nearly 14 percent. The latter amount reflects total health care expenditures, which includes amounts for research, construction and other activities that are not included in compiling personal health expenditures.

[5] Market Decisions, Citizen Perceptions of Health Care Issues, July 2000

[6] *Id.*

[7] An Aggregate Comparison: Maine and Idaho Hospitals, Maine Health Data Organization, September, 1999.

[8] Critical Insights, *op. cit.*

[9] Market Decisions, *op.cit.*

[10] Maine Health Data Organization, 1999.

[11] Journal of State Government, 1980.

[12] Maine Medical Assessment Foundation, 1983.

[13] Journal of Rural Health, 1999.

[14] Critical Insights, *op. cit.*

[15] Critical Insights, *op. cit.*

[16] Market Decisions, *op. cit.*

[17] Maine Development Foundation, 2000.

[18] Critical Insights, *op.cit.*

[19] *Id.*

[20] *Id.*

[21] *Id.*

Chapter 3
THE PROBLEM WITH HEALTH CARE IN MAINE

Armed with at least a partial understanding of the myriad social factors that affect health care in Maine, as well as with data analysis (discussed in the previous chapter) upon which to peg our real work, we began to organize our problem statement. Holding the *cost* of health as paramount, while recognizing that it is inextricably entwined with issues of access and quality, we divided the problem of high health care costs into three contributory elements, described below. Taken together, these elements not only drive up costs, they generate confusion, frustration, and general dissatisfaction. Such exasperation often precludes meaningful discussion of possible solutions. In other words, the sheer enormity of the problems seems to overwhelm most efforts to fix them.

A. The health care delivery and financing system is inefficient, unreasonably complicated, and unfair.

Whether the nation is spending too much on health care may be debatable, but markedly inefficient spending is an integral part of the system. Among industrialized nations, the United States gets far less for its health care dollar than do most other countries. According to the World Health Organization, this nation ranks only 37th out of 191 countries on several measures of health system performance. Although some have criticized the report's methodology, the fact remains that the world's richest country does not have the world's best health care system.

Expensive, duplicative administrative requirements are one of the reasons for poor value in our health care system. All estimates of administrative costs or health outcomes as related to expenditures are poor in comparison to the rest of the world.[1] Indeed, PaineWebber estimates that administration and inefficiency account for approximately 25 percent of the total annual U.S. healthcare expenditures.[2] Certain administrative costs are necessary, of course, but a figure of 25 percent seems high. In Maine alone, a 25 percent administrative outlay would have meant more than *$1 billion* in 1999.

Finally, and perhaps most tragically, a recent report states that the nation's health care delivery is prone to an excessive incidence of medical errors: that they cause 45,000 to 98,000 deaths annually in the United States.[3] In Maine, that would mean roughly one person dies each day as a result of medical error.

In addition to both administrative and medical inefficiency, there is considerable variability in how "fairly" Mainers are treated by the health care system. Two people receiving the same treatment might pay vastly different amounts out of their own pockets depending on their employment status, socioeconomic standing, age, and where they live. Related, people also have varying degrees of access to health care services based on demographic characteristics. The fact that charges are only somewhat related to cost connotes unfairness.

Providing insurance coverage at lower rates to people who are less likely to need it is a standard approach to lower costs. Indeed, insurance premiums cost less for those who are healthy and less at risk of becoming ill. People who are at greater risk of needing health care are left in a "pool" which, as a group, demand higher levels of care which translate into higher premium costs. As premium costs rise, the

most healthy in the pool opt out making the residual pool even less healthy and even more expensive. This is known as adverse selection and exacerbates the problem of uneven treatment based on socioeconomic characteristics.

B. People in Maine are not as healthy as they could be, and efforts to improve health status are inadequate.

While there are encouraging signs of improving awareness, such as the recent Healthy Maine 2000 conference and the antismoking campaign, Maine has numerous public health problems that are not yet being addressed comprehensively: alcohol and drug abuse, poor diet, sexually transmitted diseases, workplace safety, domestic violence, lack of exercise, and obesity, among them.

A survey by Maine Turning Point indicates considerable public support for public health efforts. A clear majority of respondents indicated that "delivering preventive medical care to keep people healthy" was their most important public health concern, and that they would be willing to pay fees or higher taxes to fund such initiatives. That willingness would pay off in the long term. If coronary bypass surgery and angioplasty—which are often the result of poor health choices—were reduced by only 20 percent, for example, the state would save $38.3 million a year.[4]

On the other hand, the Market Decisions survey reports:

> "When prompted about personal responsibility, less than a majority (42 percent) of respondents cited maintaining a health lifestyle as a personal step to reduce health care costs. Some 53 percent, say they "can't do anything or there is nothing that they can do" to reduce health care costs."[5]

In fact, of the seven most frequently given responses by consumers as to what accounts for the high cost of health care in Maine, greed accounted for three: on the part of insurance companies, on the part of pharmaceutical companies, and simply in general. There is apparently a disconnect between what Mainers are willing to pay for and what they are willing to do themselves.

Among adults, there are encouraging signs; dramatic examples of how relatively simple, low-cost programs can have major effects. Beginning in the 1970s, physicians in Franklin County, perceiving the widening gap between preventive medicine and the dominant fee-for-service system began offering free blood pressure screenings in an effort to reach the entire population. The county's public preventive programs have since increased in scope and sophistication. By the late 1990s, they were reporting measurable and significant improvements in cardiovascular health. The implications, both for building a healthier population, and controlling health care costs, are profound.

C. Many in Maine are unable to obtain health care of the type and quality that they need.

"Access" is a significant problem in health care in Maine: access to insurance; access to physicians; access to hospitals; access to relevant data and information of all kinds; and access to sustained, systemic public health efforts Access in all those areas depends greatly on geography and socioeconomic status, as well as on an ability to comprehend the system.

In recent years, medical costs for most people have risen at a much faster rate than their incomes. Ability to pay for medical care has become increasingly difficult for many, and has reached crisis proportions for some.

In fact, Maine (along with Hawaii, Massachusetts, Wisconsin and Washington) is among the five states with the highest insurance rates in the nation.[6] Obviously, then, a growing number of Mainers cannot pay for even the most basic health care insurance. The problem is particularly acute for employees of small businesses, who comprise the largest working population in Maine. Smaller employers, faced with increases in premium costs of between 15 and 40 percent since 1998, are increasingly unable to provide comprehensive health care for their employees. Even larger employers saw increases in that time of 8 to 20 percent.[7] Contributing factors to relatively high insurance rates include: poor health status, low population density, and government mandated universal availability.

High insurance rates have a direct bearing on access to health care: those without insurance are far less likely to seek care even if they feel they need it. In a recent study of the uninsured, for example, researchers found that 25 percent of children without insurance had unmet health needs, and that 15 percent of uninsured adults were going without needed medical care[8]. Such delay—or denial—of health care often results in more serious health problems. The result may be death or diminished quality of life, as well as increased long-term costs to an individual or to society.

Given the distribution of Maine's population, geography is also a significant factor in access. Those in more populous parts of the state have more opportunities for care. The southern part of the state simply has more physicians and more hospitals in closer proximity to where people live.

The much-discussed problem of pharmaceuticals is also an issue of access. For a large segment of the population, both insured and uninsured, paying for prescription drugs is becoming exceptionally difficult. The problem is particularly acute for the elderly: in 1998 alone the price of the 50 drugs that population takes most often rose by more than four times the rate of inflation.[9] When one considers that more than one third of all Medicare recipients lack prescription drug coverage, that nearly half of them have incomes below 200 percent of the poverty level—about $15,500 for an individual, $21,00 per couple—and that nearly 80 percent of them must take prescription drugs regularly, it is easy to see why the situation is of such fiscal and social concern.

Finally, expectations as to the type and quality of health care to which Mainers are entitled are largely undefined. Although guidelines for federal programs such as Cub Care are in place, the state as a whole has not determined procedures for consistent actual or prophylactic health care. In addition, Mainers often lack mental health services, as well as dental care. Thus, many receive far poorer overall care—and fewer services— at a higher price than they expect or can afford.

[1] PaineWebber, *Industry Outlook*, April 25, 2000.
[2] *Id*.
[3] National Institute of Medicine, "To Err is Human: Building a Safer Health Care System," 2000.
[4] Maine Turning Point, "Survey Shows Mainers Willing to Pay for Better Health," press release, May 8, 2000.
[5] Market Decisions, *op.cit*.
[6] *Michaud*, op. cit.
[7] *John E. McDonough, "Health Care Jitters,"* CommonWealth, *Summer 2000.*
[8] *Ormond, Salley, Kilbreth,* op.cit.
[9] The League of Women Voters and the Henry J. Kaiser Family Foundation, *Your Guide to Health Issues in the 2000 Election*, 2000.

Chapter 4
PRINCIPLES

Having identified the societal, governmental, market, and personal-responsibility elements of health care costs, as well as what is driving and shifting those costs, we attempted a set of principles to guide future policies and activities. Doing so reminded us of a dialogue from Lewis Carroll's *Alice in Wonderland*. "Would you tell me, please," asked Alice of the Cheshire cat, " where to go from here?" "That depends a great deal on where you want to get to," the cat replied. We think that the question of how to stabilize health care costs is similar; and that the best way to determine our destination is to develop a set of principles before beginning the journey.

The commission's principles are based on deep concern, in part on science, in part on experience, and in part on our faith on the good sense and compassion of Maine's citizens. They are not presented as absolutes, but as a foundation for a statewide discussion of our public values, our societal priorities, and our ethics that ought to guide our overall approach to health policy and finance. We intend them to be developed further by the citizens of Maine in cooperation with their elected officials, their non-governmental organizations, and private sector leaders.

Key Principles

Access

1. All Maine citizens should have ready access to basic health care regardless of income, location, or pre-existing or chronic conditions.

Quality

2. Maine's health care system should be characterized by excellence, zero tolerance for medical errors, and appropriateness of care in accordance with outcome-based evidence.

Efficiency

3. An increasing portion of the state's health care expenditures should go directly to disease prevention and public health efforts.

Supporting Principles

Personal and Community Responsibility

4. Primary responsibility for individual health lies with each person's ability to make wise decisions on individual behavior, as well as informed decisions with regard to preventive care and treatment of disease.

5. Individuals receiving health care should be aware of the cost of that care, and make health care decisions based on their needs and on the quality, service, and cost of potential treatments.

6. Community norms should greatly affect personal behavior choices.

The System

7. The health and satisfaction of the individual consumer should be the focus of the system.

8. Health care delivery and financing should be relatively simple, transparent, and understandable by consumers.

9. The health care system should encourage innovation and entrepreneurial approaches to solving complex problems.

10. There should be a shared sense of fairness about how costs are allocated and shared.

11. Information about health status, incidence of disease, treatment outcomes, and costs should be readily available in formats conducive to policy planning and individual decision making about behavior and disease treatment.

Role of State Government

12. State government should provide leadership and develop and maintain a statewide, long-term plan for coordinated health care delivery and financing based on demographic and economic trends, outcome performance measures, and citizen input.

13. State government should maximize leverage of federal government health care resources.

14. State government should streamline regulations in order to maximize opportunities for efficiencies and where state government action is necessary and appropriate, favor behavior incentives over punitive regulation.

15. State government has a minimum threshold responsibility to promote and maintain public health.